		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007534

Facility Name: Rest Haven Illiana Christian

Address: 13259 South Central Avenue (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708) 597-1000 **Fax #** (708) 389-9990

IDPA ID Number: 362382853002

Date of Initial License for Current Owners: 02/10/60

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	193	TOTALS	193	70,445	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,183	1,548	8,719	12,450	8
9	SNF/PED					9
10	ICF	31,211	21,188	12	52,411	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,394	22,736	8,731	64,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.07%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/10/60

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 27 and days of care provided 8,719

Medicare Intermediary AdminaStar Federal, Inc

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	452,943	82,827	17,485	553,255		553,255		553,255			1
2	Food Purchase		413,009		413,009		413,009	(14,363)	398,646			2
3	Housekeeping	245,289	68,112		313,401		313,401		313,401			3
4	Laundry	74,970	21,961		96,931		96,931	(12,390)	84,541			4
5	Heat and Other Utilities			192,445	192,445		192,445	2,618	195,063			5
6	Maintenance	74,115		160,659	234,774		234,774	1,963	236,737			6
7	Other (specify):*											7
8	**TOTAL General Services**	847,317	585,909	370,589	1,803,815		1,803,815	(22,172)	1,781,643			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,924,352	402,741	296,989	4,624,082		4,624,082	(2,136)	4,621,946			10
10a	Therapy			525,559	525,559		525,559	419,307	944,866			10a
11	Activities	109,687	27,394	347	137,428		137,428	(13,883)	123,545			11
12	Social Services	128,597	4,450	3,123	136,170		136,170		136,170			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,162,636	434,585	840,418	5,437,639		5,437,639	403,288	5,840,927			16
	C. General Administration											
17	Administrative	76,157		124,815	200,972		200,972	(124,815)	76,157			17
18	Directors Fees											18
19	Professional Services			48,511	48,511		48,511	(1,986)	46,525			19
20	Dues, Fees, Subscriptions & Promotions			51,744	51,744		51,744	3,280	55,024			20
21	Clerical & General Office Expenses	668,919	23,646	112,616	805,181		805,181	49,763	854,944			21
22	Employee Benefits & Payroll Taxes			891,005	891,005		891,005	68,577	959,582			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,666	15,666		15,666	9,247	24,913			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,497	62,497		62,497	11,359	73,856			26
27	Other (specify):*											27
28	**TOTAL General Administration**	745,076	23,646	1,306,854	2,075,576		2,075,576	15,425	2,091,001			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,755,029	1,044,140	2,517,861	9,317,030		9,317,030	396,541	9,713,571			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rest Haven Illiana Christian #0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			515,291	515,291		515,291	65,144	580,435			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,534	111,534		111,534		111,534			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							8,675	8,675			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			626,825	626,825		626,825	73,819	700,644			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		475,193	33,680	508,873		508,873		508,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,737	108,737		108,737		108,737			42
43	Other (specify):* Nonallowable costs			503,684	503,684		503,684	(503,684)				43
44	**TOTAL Special Cost Centers**		475,193	646,101	1,121,294		1,121,294	(503,684)	617,610			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,755,029	1,519,333	3,790,787	11,065,149		11,065,149	(33,324)	11,031,825			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
****See schedule of adjustments attached at end of cost report**

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,363)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,543)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(12,390)	4		8
9	Non-Straightline Depreciation	43,418	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,136)	10		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(373,403)	43		24
25	Fund Raising, Advertising and Promotional	(13,840)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,599)	43		28
29	Other-Attach Schedule See Sch5A	286,116			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (105,740)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	72,416		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 72,416		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (33,324)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	**Rest Haven Illiana Christian**
PROVIDER #	**0007534**
Period Ending	**12/31/01**

Schedule 5A

VI. ADJUSTMENT DETAIL

LINE 29 - Other

Description	Amount	Schedule V Reference
Gift Gratuities	(1,348)	43
Development	(342)	43
Signs	(19)	43
Directories	(100)	43
Trade Shows	(2,816)	43
Civic/Church	(9,852)	43
Interehab Physiatry	(69,531)	43
Medicare Ancillary X-ray	(24,850)	43
Medicare Lab Ancillary	(1,984)	43
Disallow Resident Welfare	(13,883)	11
Disallow Out of Period Legal	(7,275)	19
Disallow Non-allowable Dues	(193)	20
Employee Education	(998)	22
Therapy Adjustment	419,307	10A
Total	**286,116**	

See Accountants' Compilation Report

Rest Haven Illiana Christian

ID# 0007534

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,363)	0	0	0	0	0	0	0	0	0	0	(14,363)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(12,390)	0	0	0	0	0	0	0	0	0	0	(12,390)	4
5	Heat and Other Utilities	0	2,618	0	0	0	0	0	0	0	0	0	2,618	5
6	Maintenance	0	1,963	0	0	0	0	0	0	0	0	0	1,963	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(26,753)	4,581	0	0	0	0	0	0	0	0	0	(22,172)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,136)	0	0	0	0	0	0	0	0	0	0	(2,136)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,136)	0	0	0	0	0	0	0	0	0	0	(2,136)	16
	C. General Administration													
17	Administrative	0	(124,815)	0	0	0	0	0	0	0	0	0	(124,815)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,289	0	0	0	0	0	0	0	0	0	5,289	19
20	Fees, Subscriptions & Promotions	0	3,473	0	0	0	0	0	0	0	0	0	3,473	20
21	Clerical & General Office Expenses	(13,543)	63,306	0	0	0	0	0	0	0	0	0	49,763	21
22	Employee Benefits & Payroll Taxes	0	69,575	0	0	0	0	0	0	0	0	0	69,575	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,247	0	0	0	0	0	0	0	0	0	9,247	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	11,359	0	0	0	0	0	0	0	0	0	11,359	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,543)	37,434	0	0	0	0	0	0	0	0	0	23,891	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,432)	42,015	0	0	0	0	0	0	0	0	0	(417)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Rest Haven Illiana Christian **#** 0007534 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	43,418	21,726	0	0	0	0	0	0	0	0	0	65,144	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,675	0	0	0	0	0	0	0	0	0	8,675	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	43,418	30,401	0	0	0	0	0	0	0	0	0	73,819	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(392,842)	0	0	0	0	0	0	0	0	0	0	(392,842)	43
44	**TOTAL Special Cost Centers**	(392,842)	0	0	0	0	0	0	0	0	0	0	(392,842)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(391,856)	72,416	0	0	0	0	0	0	0	0	0	(319,440)	45

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian		Rest Haven West	Downers Grove	Holland Home	South Holland	Sheltered Care
Convalescent Home	100 %	Rest Haven South	South Holland	Village Woods	Crete	Independent Ret.
				Saratoga Grove	Downers Grove	Sheltered Care
				Providence Mgmt.		
				Development Co.	South Holland	Management
				Providence Home		
				Health Care	South Holland	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 2,618	$ 2,618	1
2	V	6	Maintenance supplies		Rest Haven Illiana Christian Convalescent Home	100.00%	1,963	1,963	2
3	V	17	Administrative	124,815	Rest Haven Illiana Christian Convalescent Home	100.00%		(124,815)	3
4	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	5,289	5,289	4
5	V	20	Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	3,473	3,473	5
6	V	21	Office		Rest Haven Illiana Christian Convalescent Home	100.00%	63,306	63,306	6
7	V	22	Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	69,575	69,575	7
8	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	9,247	9,247	8
9	V	26	Insurance		Rest Haven Illiana Christian Convalescent Home	100.00%	11,359	11,359	9
10	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	21,726	21,726	10
11	V	34	Rent		Rest Haven Illiana Christian Convalescent Home	100.00%	8,675	8,675	11
12	V								12
13	V								13
14	Total			$ 124,815			$ 197,231	$ * 72,416	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5		N/A - Voluntary Board with no compensation. See attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 12450 West Cheshire Court
City / State / Zip Code: Lockport, IL 60441
Phone Number: (708) 645-2115
Fax Number: (708) 8772103

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost B	64,669,983	14	$ 15,963	$ 0	10,604,147	$ 2,618	1
2	6	Maintenance Supplies	Accumulated Cost B	64,669,983	14	11,972	0	10,604,147	1,963	2
3	19	Professional Services	Accumulated Cost B	64,669,983	14	32,253	0	10,604,147	5,289	3
4	20	Fees, Subscriptions	Accumulated Cost B	64,669,983	14	21,178	0	10,604,147	3,473	4
5	21	Clerical & General Office Exp.	Accumulated Cost B	64,669,983	14	386,073	0	10,604,147	63,306	5
6	22	Employee Benefits	Accumulated Cost B	64,669,983	14	379,489	0	10,604,147	62,226	6
7	22	Employee Benefits	Direct Cost A	1	1	7,349	0	1	7,349	7
8	24	Travel & Seminar	Accumulated Cost B	64,669,983	14	56,391	0	10,604,147	9,247	8
9	26	Insurance	Accumulated Cost B	64,669,983	14	69,272	0	10,604,147	11,359	9
10	30	Depreciation	Accumulated Cost B	64,669,983	14	132,497	0	10,604,147	21,726	10
11	34	Rent - Facility & Grounds	Accumulated Cost B	64,669,983	14	52,902	0	10,604,147	8,675	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,165,339	$		$ 197,231	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bond		X	Mortgage & Additions	$30,500-Annual	2/26/97	$ 2,900,000	$ 2,749,500	02/26/27	0.0485	$ 110,524	1
2	Notes		X	Building Improvements	Varies	2001	7,000	7,000	Various	None	None	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,907,000	$ 2,756,500			$ 110,524	9
	B. Non-Facility Related*											
10	Bond Issuance Related Interest										1,010	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,010	14
15	TOTALS (line 9+line14)						$ 2,907,000	$ 2,756,500			$ 111,534	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ N/A	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven Illiana Christiar COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007534

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 645-2115 FAX #: (708) 877-2103

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	441,662	1960	$ 30,000	1
2					2
3	TOTALS	441,662		$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50			1960	$ 341,041	$ 8,526	40	$ 8,526	$	$ 358,092	4
5	50			1962	122,119	3,053	40	3,053		122,120	5
6				1963	86,546	2,164	40	2,164		84,396	6
7	93			1967	585,862	14,647	40	14,647		512,645	7
8				1975	147,301	3,683	40	3,683		99,420	8
	Improvement Type**										
9	Improvements			1967	312,475	7,812	40	7,812		270,526	9
10	Improvements			1970	74,824	1,871	40	1,871		59,872	10
11	Improvements			1971	10,740	269	40	269		8,339	11
12	Improvements			1972	3,992	100	40	100		3,000	12
13	Improvements			1973	2,002	50	40	50		1,417	13
14	Improvements			1974	1,001	25	40	25		680	14
15	Improvements			1976	8,418	210	40	210		5,350	15
16	Improvements			1977	1,073	27	40	27		657	16
17	Improvements			1979	450	11	40	11		253	17
18	Improvements			1980	629	16	40	16		352	18
19	Improvements			1982	3,077	77	40	77		1,540	19
20	Improvements			1983	4,063	102	40	102		1,938	20
21	Improvements			1984	11,366	284	40	284		5,112	21
22	Improvements			1985	5,552	139	40	139		2,363	22
23	Improvements			1986	308,545	7,714	40	7,714		123,424	23
24	Improvements			1987	242,285	6,057	40	6,057		90,855	24
25	Improvements			1988	144,720	3,618	40	3,618		39,320	25
26	Improvements			1989	75,090	1,877	40	1,877		24,392	26
27	Improvements			1990	258,016	6,450	40	6,450		80,780	27
28	Improvements			1991	88,476	2,212	40	2,212		26,064	28
29	Improvements			1992	51,572	1,289	40	1,289		12,890	29
30	Improvements			1993	283,946	7,099	40	7,099		64,480	30
31	Improvements			1994	396,618	9,915	40	9,915		80,334	31
32	Improvements			1995	207,113	5,526	40	5,526		35,188	32
33	Improvements			1995	13,913	928	15	928		6,032	33
34	Parking Lot Expansion			1996	74,714	1,868	40	1,868		10,274	34
35	Wing C & D Renovations			1996	226,501	5,662	40	5,662		31,141	35
36	Wing A & B Renovations			1996	279,308	6,982	40	6,982		38,401	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dental Office Renovations	1996	$ 4,642	$ 310	15	$ 310	$	$ 1,705	37
38	Lighting System	1996	49,263	1,232	40	1,232		6,776	38
39	Architect Fees	1996	13,512	338	40	338		1,859	39
40	Alarm System	1996	4,704	314	15	314		1,727	40
41	Whirlpool Renovation	1996	11,914	794	15	794		4,367	41
42	Door	1996	656	44	15	44		242	42
43									43
44	Unit I & II Renovation	1996	22,981	574	40	574		3,157	44
45	Landscaping	1997	5,984	398	15	398		1,791	45
46	Unit I A & B remodel:Carpentry, elec. Plumb	1997	236,778	9,472	25	9,472		42,625	46
47	Unit I C & D remodel:Carpentry, elec. plumb.	1997	211,804	8,472	25	8,472		38,124	47
48	Unit I Whirlpool Renovation	1997	3,264	130	25	130		585	48
49	Unit II Whirlpool Renovation	1997	3,910	156	25	156		702	49
50	Plumbing	1997	1,595	64	25	64		288	50
51	Unit II Laundry Room Cabinets	1997	729	30	25	30		135	51
52	Chapel Roof	1997	8,750	350	25	350		1,575	52
53	Ramp Entrance	1997	32,456	1,298	25	1,298		5,841	53
54	Employee Patio	1997	3,975	159	25	159		716	54
55	Ramp Curbing	1997	1,396	56	25	56		252	55
56	Stairwell Doors	1997	1,833	74	25	74		333	56
57	Handicap Ramp	1997	12,166	486	25	486		2,187	57
58	Medical Supply Room Renovation	1997	20,773	830	25	830		3,735	58
59	Unit II A & B remodel:Carpentry, fire protection	1997	78,500	3,140	25	3,140		14,130	59
60	A & B Basement Remodeling	1997	2,331	94	25	94		423	60
61	Unit II Storage Room	1997	3,458	138	25	138		621	61
62	Unit I A & B remodel:Carpentry, elec., tile	1998	18,389	736	25	736		12,486	62
63	Unit II Handicap Ramp	1998	2,002	80	25	80		280	63
64	Unit II Storage Room	1998	8,807	352	25	352		1,232	64
65	Unit II A & B Bsmnt remodel:Carpty, elec, plumb.	1998	83,634	3,345	25	3,345		11,708	65
66	Unit I A & B remodel:Carpty,plmg, elec.	1998	19,906	796	25	796		2,786	66
67	Unit II A & B Bsmt remodel:Carpty & fire prot.	1998	10,676	427	25	427		1,495	67
68	Design Plan for Renovation	1998	706	28	25	28		98	68
69	Unit II A & B Bsmt remodel:Carpentry & fee	1998	2,314	93	25	93		325	69
70	TOTAL (lines 4 thru 69)		$ 5,257,156	$ 145,073		$ 145,073	$	$ 2,365,953	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,257,156	$ 145,073		$ 145,073	$	$ 2,365,953	1
2	Painting for Renovation	1998	3,873	154	25	154		539	2
3	Unit I A & B remodel:Carpty,& finishing	1998	20,171	806	25	806		2,821	3
4	Carpeting	1998	13,997	2,800	5	2,800		9,800	4
5	Unit I A & B remodel:Carpty, plmg, fire	1998	8,026	322	25	322		1,127	5
6	Unit II Patio /Alzheimer's Garden	1998	49,519	1,980	25	1,980		6,930	6
7	Hot Water Heater	1998	831	56	15	56		196	7
8	Roof	1998	991	100	10	100		350	8
9	A/C Circulator	1998	1,115	74	15	74		259	9
10	Chimney Vent	1998	519	20	25	20		70	10
11	Fascia	1998	789	32	25	32		112	11
12	Smoke Detectors	1998	1,081	72	15	72		252	12
13	Speed Bumps for Parking Lot	1998	781	156	5	156		546	13
14	Heating & Cooling System	1998	34,826	1,394	25	1,394		4,879	14
15	Nurses' Alarm System	1998	13,917	556	25	556		1,946	15
16	Piping	1998	682	28	25	28		98	16
17	Patio	1999	10,472	262	40	262		655	17
18	Carpeting	1999	6,283	628	10	628		1,570	18
19	Electrical Generator	1999	66,394	6,640	10	6,640		16,600	19
20	Wall Firestopping	1999	15,000	1,500	10	1,500		3,750	20
21	Interior design fee	1999	228	22	10	22		55	21
22	Electrical	1999	4,383	438	10	438		1,095	22
23	Wall Firestopping	1999	35,000	3,500	10	3,500		8,750	23
24	Switchboard	1999	5,696	570	10	570		1,425	24
25	Landscaping	1999	48,376	1,210	10	1,210		3,025	25
26	Parking Lot	1999	8,610	216	40	216		540	26
27	Air Conditioners	1999	80,030	8,004	40	8,004		20,010	27
28	Boiler Repairs	1999	9,060		10	906	906	2,265	28
29	Landscaping	2000	10,704	712	15	712		1,068	29
30	Patio Shelter	2000	5,150	256	20	256		384	30
31	Garden	2000	7,768	516	15	516		774	31
32	Benches	2000	958	94	10	94		141	32
33	Lobby remodel	2000	102,660	10,266	10	10,266		15,399	33
34	TOTAL (lines 1 thru 33)		$ 5,825,046	$ 188,457		$ 189,363	$ 906	$ 2,473,384	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,825,046	$ 188,457		$ 189,363	$ 906	$ 2,473,384	1
2	Dining Room Renovation	2000	6,269	416	15	416		624	2
3	Wing Renovation	2000	102,095	2,552	40	2,552		3,828	3
4	Boiler and Pump	2000	10,450	696	15	696		1,044	4
5	Ansul	2000	3,728	248	15	248		372	5
6	Generator	2000	8,629	430	20	430		645	6
7	Fire Alarm System	2000	10,135	252	40	252		378	7
8	Exhaust Fan	2000	2,780	184	15	184		276	8
9	Landscaping	2001	5,680	568	5	568		568	9
10	Lobby remodel	2001	41,806	523	40	523		523	10
11	A-Wing remodel	2001	51,393	643	40	643		643	11
12	Sinks	2001	5,165	172	15	172		172	12
13	Doors	2001	5,278	176	15	176		176	13
14	Ejector Pump	2001	9,674	323	15	323		323	14
15	Automatic door	2001	4,817	344	7	344		344	15
16	Dining Room Renovation	2001	3,076	220	7	220		220	16
17	Exam Room Decoration	2001	14,068	1,005	7	1,005		1,005	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation adjustment for assets disallowed for medicaid purposes.			113,709			(113,709)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,110,089	$ 310,918		$ 198,115	$ (112,803)	$ 2,484,525	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,110,089	$ 310,918		$ 198,115	$ (112,803)	$ 2,484,525	1
2									2
3									3
4									4
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,110,089	$ 310,918		$ 198,115	$ (112,803)	$ 2,484,525	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,332,241	$ 188,033	$ 344,254	$ 156,221	Various	$ 3,042,995	71
72	Current Year Purchases	132,940	16,340	16,340		10	16,340	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			21,726	21,726			74
75	TOTALS	$ 3,465,181	$ 204,373	$ 382,320	$ 177,947		$ 3,059,335	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,605,270	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 515,291	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 580,435	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,144	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,543,860	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				8,675			6
7	TOTAL				$ 8,675 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ N/A
13.	/2003	$ N/A
14.	/2004	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service		Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a, C 3	hrs		$	6,681	$ 361,447	$	6,681	$ 361,447	1
2	Licensed Speech and Language Development Therapist	L. 10a, C 3	hrs			1,936	129,457		1,936	129,457	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L. 10a C 2,3	hrs			7,779	453,962		7,779	453,962	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L. 39, C 2	# of prescrpts					475,193		475,193	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Lab	L. 39, C 3					33,680			33,680	13
14	TOTAL				$	16,396	$ 978,546	$ 475,193	16,396	$ 1,453,739	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,757	$ 14,757	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 400,144)	2,363,093	2,363,093	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	40,138	40,138	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,417,988	$ 2,417,988	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000	30,000	13
14	Buildings, at Historical Cost	6,104,514	6,110,089	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,679,702	3,465,181	16
17	Accumulated Depreciation (book methods)	(6,508,584)	(5,543,860)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,305,632	$ 4,061,410	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,723,620	$ 6,479,398	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 955,835	$ 955,835	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	7,000	7,000	29
30	Accrued Salaries Payable	343,567	343,567	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,413	56,413	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	7,891,146	5,141,646	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,253,961	$ 6,504,461	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,749,500	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,749,500	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,253,961	$ 9,253,961	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,530,341)	$ (2,774,563)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,723,620	$ 6,479,398	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,415,840)	1
2	Restatements (describe):		2
3			3
4	**Prior Year Adjustment Per Auditor**	(5,044)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,420,884)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(109,457)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (109,457)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,530,341)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,582,916	1
2	Discounts and Allowances for all Levels	(2,508,819)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,074,097	3
	B. Ancillary Revenue		
4	Day Care	3,017	4
5	Other Care for Outpatients		5
6	Therapy	3,030,711	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,033,728	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	14,363	14
15	Telephone, Television and Radio	13,543	15
16	Rental of Facility Space		16
17	Sale of Drugs	519,762	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,852	19
20	Radiology and X-Ray	33,877	20
21	Other Medical Services	1,197,238	21
22	Laundry	12,390	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,847,025	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Recreation Hall Income**	842	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 842	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,955,692	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,803,815	31
32	Health Care	5,437,639	32
33	General Administration	2,075,576	33
	B. Capital Expense		
34	Ownership	626,825	34
	C. Ancillary Expense		
35	Special Cost Centers	1,012,557	35
36	Provider Participation Fee	108,737	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,065,149	40
41	**Income before Income Taxes (line 30 minus line 40)****	(109,457)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (109,457)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,080	$ 50,569	$ 24.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	56,747	61,561	1,234,372	20.05	3
4	Licensed Practical Nurses	24,152	26,576	498,060	18.74	4
5	Nurse Aides & Orderlies	167,641	181,656	2,080,434	11.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,053	2,230	23,631	10.60	9
10	Activity Assistants	4,840	5,104	86,056	16.86	10
11	Social Service Workers	8,412	8,858	128,597	14.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,098	44,795	452,943	10.11	15
16	Dishwashers					16
17	Maintenance Workers	4,751	4,920	74,115	15.06	17
18	Housekeepers	23,403	25,200	245,289	9.73	18
19	Laundry	6,493	7,137	74,970	10.50	19
20	Administrator	2,080	2,080	76,157	36.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,185	31,637	668,919	21.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,979	2,079	24,458	11.76	31
32	Other Health Ca Case Manager	1,600	1,699	36,459	21.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	374,450	407,612	$ 5,755,029 *	$ 14.12	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	317	$ 17,485	L1, C3	35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant	Monthly	2,568	L10, C3	37
38	Nurse Consultant	625	15,613	L10, C3	38
39	Pharmacist Consultant	Per Visit	50	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	347	L11, C3	44
45	Social Service Consultant	5	223	L12, C3	45
46	Other(specify) Chapel Ministry	58 Visits	2,900	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	954	$ 53,586		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,640	$ 65,863	L10, C3	50
51	Licensed Practical Nurses	5,589	206,181	L10, C3	51
52	Nurse Aides	340	6,714	L10, C3	52
53	TOTAL (lines 50 - 52)	7,569	$ 278,758		53

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peter J. Klein	Administrator	0%	$ 76,157
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,157

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 124,815
TOTAL (agree to Schedule V, line 17, col. 3)	$ 124,815
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Laner, Muchin, Dombrow, Becker		$
Levin, Tominberg, Ltd.	Legal	27,100
KPMG Peat Marwick LLP	Accounting	5,110
American Express Tax	Accounting	
& Business Services.		2,820
Altschuler Melvoin &	Accounting	
Glasser LLP		8,527
SMS	Billing	4,844
AMA Profile	Administrative Services	110
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,511

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,787
Unemployment Compensation Insurance	20,412
FICA Taxes	400,133
Employee Health Insurance	16,687
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Education	1,993
Employee Medical	5,804
Drug Testing	5,265
Uniforms	7,005
TDA Expense	70,565
See Schedule 21D	285,356
Home Office Allocation	69,575
TOTAL (agree to Schedule V, line 22, col.8)	$ 959,582

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,060
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network of Illinois	15,424
Health Resources Alliance	8,333
Miscellaneous Dues & Licenses	150
Miscellaneous Subscriptions	3,669
JCAHO	14,915
Home Office Allocation	3,473
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,024

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,916
See attached schedule	
Seminar Expense	12,750
See attached schedule	
Home Office Allocation	9,247
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,913

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name **Rest Haven Illiana Christian**
PROVIDER # **0007534**
Period Ending **12/31/01**

Schedule 21C

XIX. Support Schedules
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	48,511
Out of period legal fees disallowed	(7,275)
Home Office Allocation	5,289
Total (agree to Schedule V, line 19, column 8)	46,525

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name **Rest Haven Illiana Christian**
PROVIDER # **0007534**
Period Ending **12/31/01**

Schedule 21D

XIX. Support Schedules
D. Employee Benefits and Payroll Taxes

	Amount
Health Insurance	217,895
Dental Insurance	2,103
Attendance Awards	22,905
Life & LTD	20,943
403(b) fees	5,037
Life Insurance	2,616
Employee Assistance Plan	3,600
Miscellaneous Benefits	10,257
Total	285,356

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Illiana Christian # 0007534 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSNI $15,424 HRA $8,333**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **108,737**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **14,363**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG-Peat Marwick LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	452,943	82,827	17,485	553,255	0	553,255	0	553,255
2. Food Purchase	0	413,009	0	413,009	0	413,009	-14,363	398,646
3. Housekeeping	245,289	68,112	0	313,401	0	313,401	0	313,401
4. Laundry	74,970	21,961	0	96,931	0	96,931	-12,390	84,541
5. Heat and Other Utilities	0	0	192,445	192,445	0	192,445	2,618	195,063
6. Maintenance	74,115	0	160,659	234,774	0	234,774	1,963	236,737
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	847,317	585,909	370,589	1,803,815	0	1,803,815	-22,172	1,781,643
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	3,924,352	402,741	296,989	4,624,082	0	4,624,082	-2,136	4,621,946
10a. Therapy	0	0	525,559	525,559	0	525,559	419,307	944,866
11. Activities	109,687	27,394	347	137,428	0	137,428	-13,883	123,545
12. Social Services	128,597	4,450	3,123	136,170	0	136,170	0	136,170
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,162,636	434,585	840,418	5,437,639	0	5,437,639	403,288	5,840,927
17. Administrative	76,157	0	124,815	200,972	0	200,972	-124,815	76,157
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	48,511	48,511	0	48,511	-1,986	46,525
20. Fees, Subscriptions & Promotion	0	0	51,744	51,744	0	51,744	3,280	55,024
21. Clerical & General Office	668,919	23,646	112,616	805,181	0	805,181	49,763	854,944
22. Employee Benefits & Payroll	0	0	891,005	891,005	0	891,005	68,577	959,582
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	15,666	15,666	0	15,666	9,247	24,913
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	62,497	62,497	0	62,497	11,359	73,856
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	745,076	23,646	1,306,854	2,075,576	0	2,075,576	15,425	2,091,001
29. Total General Administrative	5,755,029	1,044,140	2,517,861	9,317,030	0	9,317,030	396,541	9,713,571
30. Depreciation	0	0	515,291	515,291	0	515,291	65,144	580,435
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	111,534	111,534	0	111,534	0	111,534
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	8,675	8,675
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	626,825	626,825	0	626,825	73,819	700,644
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	475,193	33,680	508,873	0	508,873	0	508,873
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	108,737	108,737	0	108,737	0	108,737
43. Other (specify):*	0	0	503,684	503,684	0	503,684	-503,684	0
44. Total Special Cost Ce	0	475,193	646,101	1,121,294	0	1,121,294	-503,684	617,610
45. Grand Total	5,755,029	1,519,333	3,790,787	11,065,149	0	########	-33,324	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	14,757	14,757
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,363,093	2,363,093
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	40,138	40,138
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,417,988	2,417,988
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	30,000	30,000
14. Buildings, at Historical Cost	6,104,514	6,110,089
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	3,679,702	3,465,181
17. Accumulated Depreciation (book methods)	-6,508,584	-5,543,860
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	3,305,632	4,061,410
25. Total Assets	5,723,620	6,479,398
CURRENT LIABILITIES		
26. Accounts Payable	955,835	955,835
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	7,000	7,000
30. Accrued Salaries Payable	343,567	343,567
31. Accrued Taxes Payable	56,413	56,413
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	7,891,146	5,141,646
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	9,253,961	6,504,461
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	2,749,500
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	2,749,500
46.Total Liabilities	9,253,961	9,253,961
47.Total Equity	-3,530,341	-2,774,563
48.Total Liabilities and Equity	5,723,620	6,479,398

		Balance per Medicaid Trial Balance
1.	Gross Revenue - All levels of Care	8,582,916
2.	Discounts and Allowances for all Levels	-2,508,819
	Subtotal - Inpatient Care	6,074,097
4.	Day Care	3,017
5.	Other Care for Outpatients	0
6.	Therapy	3,030,711
7.	Oxygen	0
	Subtotal - Anciliary Revenue	3,033,728
9.	Payments for Education	0
10.	Other Governmental Grants	0
11.	Nurses Aide Training Reimbursements	0
12.	Gift and Coffee Shop	0
13.	Barber and Beauty Care	0
14.	Non-Patient Meals	14,363
15.	Telephone, Television, and Radio	13,543
16.	Rental of Facility Space	0
17.	Sale of Drugs	519,762
18.	Sale of Supplies to Non-Patients	0
19.	Laboratory	55,852
20.	Radiologyand X-Ray	33,877
21.	Other Medical Services	1,197,238
22.	Laundry	12,390
	Subtotal - Other Operating Revenue	1,847,025
24.	Contributions	0
25.	Interest and Other Investments Income	0
	Subtotal - Non-Operating Revenue	-
27.	Other Revenue (specify):	842
28.	Other Revenue (specify):	0
	Subtotal - Other Revenue	842
30.	Total Revenue	10,955,692
31.	General Services	1,803,815
32.	Health Care	5,437,639
33.	General Administration	2,075,576
34.	Ownership	626,825
35.	Special Cost Centers	1,012,557
35.	Provider Participation Fee	108,737
37.	Other	0
40.	Total Expenses	11,065,149
41.	Income Before Income Taxes	-109,457
42.	Income Taxes	0
43.	Net Income or Loss for the Year	-109,457

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **Rest Haven Illiana Chris** **03:57 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-33,324	equal to	-33,324	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	111,534	equal to	111,534	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	580,435	equal to	580,435	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	8,675	equal to	8,675	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	944,866	equal to	525,559	419,307	FAILED	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	475,193	equal to	475,193	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,803,815	equal to	1,803,815	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	5,437,639	equal to	5,437,639	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,075,576	equal to	2,075,576	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	626,825	equal to	626,825	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	1,012,557	equal to	1,012,557	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	108,737	equal to	108,737	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,887,893	equal to	3,924,352	-36,459	FAILED	Pg20 K11..K15+K35+K36+K38..K44	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	109,687	equal to	109,687	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	128,597	equal to	128,597	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	452,943	equal to	452,943	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	74,115	equal to	74,115	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	245,289	equal to	245,289	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	74,970	equal to	74,970	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	76,157	equal to	76,157	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	668,919	equal to	668,919	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,755,029	equal to	5,755,029	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	17,485	< or = to	17,485	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	296,989	< or = to	296,989	0	O.K.	Pg20 X14..X16+X37..X39	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	347	< or = to	347	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	223	< or = to	3,123	-2,900	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	76,157	equal to	76,157	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	124,815	equal to	124,815	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	48,511	equal to	48,511	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	959,582	equal to	959,582	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	55,024	equal to	55,024	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	24,913	equal to	24,913	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	108,737	equal to	108,737	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	68,577	-68,577	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,719	equal to	8,719	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	72,416	equal to	72,416	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,756,500	equal to	2,756,500	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	30,000	equal to	30,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,110,089	equal to	6,110,089	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	3,465,181	equal to	3,465,181	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,543,860	equal to	5,543,860	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-3,530,341	equal to	-3,530,341	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-109,457	equal to	-109,457	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,723,620	equal to	5,723,620	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1